Supreme Court, U.S.
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No. 04-

IN THE

Supreme Court of the United States

LINDA ELLIS,

Petitioner,

v.

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Despite significant and virtually unrebutted medical evidence of disability that justified the payment of long-term disability benefits for an eight month period, Liberty Life Assurance of Boston (hereinafter "Liberty Life") reversed course and abruptly terminated the disability benefits Linda Ellis (hereinafter "Ellis") was receiving under an ERISA long-term disability insurance policy. After the District Court determined Ellis was entitled to those disability benefits, the Fifth Circuit reversed the District Court in a decision that seriously conflicts with the decisions of ten other Circuits and ignores the plain language of the policy. The dissent found that there was no basis to reverse the ERISA abuse of discretion finding by the District Court. Because the Fifth Circuit's majority opinion conflicts with other Circuits on issues that are important to ERISA jurisprudence, this Court should review the following questions:

1. Whether the Fifth Circuit's Overly Restrictive "Each and Every" Construction of "Disability" that Directly Conflicts with Decisions of the Second, Ninth and Tenth Circuits is Contrary to the Uniform Construction of Disability Insurance Policies Expected under ERISA?

2. Whether the Fifth Circuit's Rendition of Judgment in Favor of Liberty Life that Conflicts with the Decisions of the Vast Majority of Other Circuits is Contrary to the Substantial Evidence Requirement of the ERISA Abuse of Discretion Standard of Review?

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Linda Ellis respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit.

OPINIONS BELOW

The decision of the Court of Appeals is reported, as revised on January 13, 2005, at 394 F.3d 262 (5th Cir. 2005). The petition for rehearing and petition for rehearing en banc were denied on January 14, 2005. The Memorandum Opinion and Order, and Supplement to Memorandum and Order of the District Court are not reported. *See* Appendices A-D.

STATEMENT OF JURISDICTION

The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254 (1). The judgment of the Court of Appeals was entered on November 19, 2004. A petition for rehearing and a petition for rehearing en banc were timely filed on December 3, 2004. The petition for rehearing and petition for rehearing en banc were denied on January 14, 2005.

STATUTES INVOLVED

The relevant provisions of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1132 are as follows:

> § 1132. Civil enforcement
>
> (a) Persons empowered to bring a civil action
>
> A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 *of this title*;

(3) by a participant, beneficiary, or fiduciary

(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or

(B) to obtain other appropriate equitable relief

(i) to redress such violations or

(ii) to enforce any provisions of this subchapter or the terms of the plan . . .

STATEMENT OF THE CASE

In November 1999, Ellis, a mortgage loan officer with Chase Manhattan Bank ("Chase"), was no longer able to perform her duties as a mortgage loan officer due to a number of conditions, including fibromyalgia. In May 2000, after receiving short-term disability (STD) benefits for six months, Ellis began receiving benefits for long-term disability (LTD) from Liberty Life based on medical records and information it had received from her physicians demonstrating her inability to perform the material duties of her occupation. On December 22, 2000, after it had paid Ellis LTD benefits for eight months, Liberty Life abruptly terminated her LTD benefits effective December 31, 2000, noting that:

> . . . it is apparent you were ill and met the criteria for your policy's definition of disability initially based on the medical information received, you no longer meet your Long Term Disability Policy's definition of disability.

The material duties of Ellis' occupation at Chase included: performing at a rapid pace 100% of the time, meeting deadlines set by others 90% of the time, significant emotional distress, persisting in the face of obstacles, producing results that consistently meet or exceed expectations, funding a minimum of $500,000 each month, maintaining a branch customer satisfaction score of 85% good or better, driving for results, building constructive financial relationships, acquiring new opportunities, demonstrating technical/marketplace expertise, and managing the customer experience. Her job involved sitting 60% of the time, lifting 2% of the time, walking 10% of the time, standing 3% of the time, reaching 5% of the time, and driving 20% of the time.

The evidence in the administrative record demonstrated that Ellis had a Class 4 Physical Impairment and a Class 4 Mental Impairment attributable to the persistent pain she was suffering; she could not work an eight hour day; she could not perform on the job driving; she could not travel in a vehicle more than thirty minutes without pain medication; she was unable to walk or stand for any significant length of time; she could not lift, push, pull, climb stairs, or make fine movements with her hands; she had memory and cognitive problems attributable to her pain; she had difficulty sleeping and grooming herself; and she could not manage financial matters. Her physicians' records revealed she suffered multiple areas of pain on palpation; she suffered significant fatigue; she met the recognized diagnostic criteria for fibromyalgia; the results of her EMGs were suggestive of a myopathic process; and the results of a muscle biopsy were also suggestive of an inflammatory myopathy.

Even Liberty Life's selected expert, Dr. Croft, could not assess her limitations; he did not identify a single duty of her occupation as a mortgage loan officer that she could perform other than sitting; he also found she was tearful when he palpated her muscles; and he found that she walked with an antalgic gait.

In April 2001, the Social Security Administration (SSA) determined Ellis had been disabled since October 29, 1999; she suffered from inflammatory myopathy, diabetes and degenerative joint disease; her testimony concerning her inability to work and her severe pain complaints was credible evidence of her impairment; she could not perform her occupation as a mortgage loan officer; and she did not have any residual functional capacity to perform sedentary work on a sustained basis.

After Liberty Life "affirmed" its termination decision in an administrative appeal in March 2001, Ellis was forced to file suit. On June 3, 2003, the District Court determined that Liberty Life had abused its discretion when it terminated Ellis' LTD benefits in December 2000. In its Memorandum Opinion and Order, the District Court determined that Ellis qualified for LTD benefits, if she was unable to perform one or more of the material duties of her job. The District Court also found "no credible, substantial or positive evidence" that demonstrated Ellis, "once eligible, became ineligible for disability benefits". In its Supplement to Memorandum Opinion and Order, the District Court also found that Liberty Life's conduct was a bad faith breach of the fiduciary duties it owed to Ellis. The District Court entered a Judgment on August 3, 2003 awarding LTD benefits, attorneys fees and prejudgment interest to Ellis. This Judgment was modified by a subsequent Order entered by the District Court on October 20, 2003.

On appeal, the Fifth Circuit reversed the District Court and rendered judgment in favor of Liberty Life. In rendering its 2-1 opinion, the majority of the Fifth Circuit panel determined that the "only" construction of "Disability" required Ellis to prove she was unable to perform "each and every" material duty of her occupation to qualify for LTD benefits. Apparently, Ellis was not "disabled", because there was evidence she could sit. In reaching this conclusion, the panel majority ignored the plain language of the Liberty Life LTD policy and the recognized rules of construction for ERISA insurance policies. The majority also ignored prior applicable Fifth Circuit authority on this issue, and its decision directly conflicts with decisions of the Second, Ninth and Tenth Circuits construing similar "own occupation" disability provisions under ERISA. The decision was also

inconsistent with decisions of the Seventh, Tenth and Eleventh Circuits construing ERISA "any occupation" disability provisions.

The Fifth Circuit's panel majority also rendered judgment for Liberty Life, even though it identified no substantial evidence, medical or otherwise, in the administrative record that supported Liberty Life's termination of Ellis' LTD benefits. This holding is clearly contrary to the recognized abuse of discretion standard of review described by the vast majority of the other Circuits, and prior decisions of the Fifth Circuit. This holding is also contrary to this Court's opinion in *The Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003).

Judge Pickering filed a dissent. In his dissent, Judge Pickering noted that the construction of "disability" found by the District Court was a reasonable construction of the policy, and it should be enforced because it was consistent with the reasonable expectations of the insured, Ellis. Judge Pickering also found no concrete evidence in the administrative record that supported Liberty Life's decision to terminate Ellis' LTD benefits, no evidence that demonstrated Liberty Life's prior decision to pay LTD benefits to Ellis was incorrect, and no evidence that Ellis' medical condition had significantly changed. Under the ERISA abuse of discretion standard of review, Judge Pickering believed the Fifth Circuit was compelled to affirm the District Court's finding that Liberty Life abused its discretion.

Although the foregoing issues were raised in a petition for rehearing and a petition for rehearing en banc, the majority refused to correct its opinion and denied Ellis' petitions for rehearing on January 14, 2005.[1]

REASONS FOR GRANTING THE PETITION

1. The Fifth Circuit's Overly Restrictive Construction of "Disability" Conflicts with the Decisions of Other Circuits, and the Plain Language of the Chase LTD Policy.

As is well-recognized by the federal courts, the construction of an ERISA insurance policy begins with the provisions of the insurance policy. Liberty Life's LTD policy provides, in pertinent part, as follows:

> ***Section 2, Definitions***
>
> ***"Disability"*** or ***"Disabled"*** means during the Elimination Period and the next 24 months of Disability, the Covered Person is unable to perform all of the material and substantial duties of his occupation on an Active Employment basis because of an Injury or Sickness . . .

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[1] Judge Pickering's term expired in December 2004 and he did not participate in the consideration of the petitions for rehearing.

Section 4- Disability Income Benefits

Amount of Disability Monthly Benefit

To figure the amount of Monthly Benefit:

1. Multiply the Covered Person's Basic Monthly Earnings by the Benefit Percentage shown in the Schedule of Benefits.

Quick Recovery Program (Plus)

When proof is received that a Covered Person is Partially Disabled and has experienced a loss of earnings because of an Injury or Sickness, he may be eligible to receive a Loss of Earnings Monthly Benefit under Liberty's Quick Recovery Program (Plus).

To be eligible to receive such benefits, the Covered Person may be employed in his own occupation or another occupation and:

1. must satisfy the Elimination Period, and

2. must be earning 20% or more of his Pre-Disability Earnings.

If the Covered Person is earning less than 20% of his Pre-Disability Earnings, ***the Disability Benefit*** will be paid, and all other benefit provisions and terms applicable to ***Disability*** will apply as stated in this coverage.

For the purposes of this provision, the Covered Person may satisfy the Elimination Period if he is Disabled or Partially Disabled or a combination of Disabled or Partially Disabled during such time.

"***Partial Disability***" or "***Partially Disabled***" means as a result of the Injury or Sickness, the Covered Person is:

1. able to perform one or more, but not all, of the material and substantial duties of his own occupation or any other occupation on an Active Employment or a part-time basis, or

2. able to perform all of the material and substantial duties of his own or any other occupation on a part-time basis.

Amount of Loss of Earnings Monthly Benefit

To figure the amount of Monthly Benefit the formula (A divided by B) x C will be used:

A= The Covered Person's Pre-Disability Earnings minus the Covered Person's Basic Monthly Earnings received while he is Partially Disabled.

B= The Covered Person's Pre-Disability Earnings.

C= The Monthly Benefit as figured under the Disability provision of this coverage, (but not including adjustments under the Cost of Living Adjustment Benefit, if any).

(Emphasis added).

According to the majority opinion rendered by the Fifth Circuit, Ellis only qualifies for the "Disability Benefit" under the foregoing provisions, if she has a complete inability to perform "each and every" material and substantial duty of her occupation. If she can perform any single material duty of her occupation, she is not entitled to receive the "Disability Benefit". (App. A, *infra*, at pp. 12a, 16a-17a).

This construction of the foregoing provisions conflicts with decisions of the Second, Ninth and Tenth Circuits construing similar "own occupation" disability provisions in ERISA insurance policies; it conflicts with decisions of the Seventh, Tenth and Eleventh Circuits construing "any occupation" provisions in ERISA insurance policies; it ignores prior Fifth Circuit precedent that rejected such a construction; and it is contrary to the plain language of the foregoing provisions and the reasonable expectations of Liberty Life's insured, Ellis. Given the importance of uniformity in the construction of disability insurance policies under ERISA, these conflicts raise a substantial question of exceptional importance that justifies review by this Court.

A. The "Each and Every" Construction Adopted by the Fifth Circuit Conflicts with the Decisions of Other Circuits.

The Second, Ninth and Tenth Circuits have rejected, explicitly or implicitly, the "each and every" construction adopted by the majority of the Fifth Circuit panel in this case. These Courts of Appeals, utilizing the practical common sense approach recognized under ERISA, have each determined that the correct construction of "disability" allows an insured to recover total disability income benefits, if there is a task an insured cannot perform that is vital or essential to the insured's performance of her job. *Caldwell v. Life Insurance Company of North America*, 287 F.3d 1276, 1285-86 (10th Cir. 2002); *Kinstler v. First Reliance Standard Life Insurance Company*, 181 F.3d 243, 253 (2d Cir. 1999); *Saffle v. Sierra Pacific Power Co. Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455, 458-59 (9th Cir. 1996); and *McClure v. Life Insurance Company of North America*, 84 F.3d 1129, 1133-34 (9th Cir. 1996).

A brief review of these Circuit Court cases further exemplifies the conflict this Court should resolve. In *McClure*, the Ninth Circuit construed a definition of "disability" that required the insured to prove "a complete inability ... to perform every duty of his occupation". 84 F.3d at 1133. The Ninth Circuit found the term "every" to be ambiguous, because it could mean "all" and it could mean "each". *McClure*, 84 F.3d at 1134. The *McClure* court construed the definition "in a practical sense" and found that "total disability exists if an employee is unable to perform one of the essential duties of his or her position". *Id.*

Saffle rejected "each and every" interpretations that either disqualify or qualify virtually every insured, as not wholly sensible or reasonable. 85 F.3d at 458-59. In *Saffle*, the Ninth Circuit found a reasonable interpretation of "Disability" to be one that required the insured to prove she was only unable to perform a substantial portion of her duties. 85 F.3d at 458.

The Second Circuit has determined that an inability to perform some, but not all, of the essential duties of an insured's job qualifies the insured for total disability. *Kinstler*, 181 F.3d at 253. In *Kinstler*, the insured was unable to perform the clinical duties of her job, such as providing direct patient care, and responding to medical crises; however, she could perform her sedentary administrative duties that comprised 60% of her job function. 181 F.3d at 247, 253. The Second Circuit determined the insured was entitled to LTD benefits, because she could not perform her clinical duties. *Kinstler*, 181 F.3d at 253.

In *Caldwell*, the insured was a customer service representative who had primarily sedentary duties, but who was also required to perform the heavy lifting duties of a rig hand as well. 287 F.3d at 1279-80. The definition of "disability" in the "own occupation" period was "unable to perform all the essential duties of his job". *Caldwell*, 287 F.3d at 1279. Although he admitted he could perform the sedentary duties of his job, the Tenth Circuit found that Caldwell could not perform all the essential duties of his job, because he could not perform the heavy lifting duties of a rig hand he was also required to perform. *Caldwell*, 287 F.3d at 1284-85. The Tenth Circuit agreed with a district court's determination that the insurer's denial of "own occupation" disability benefits to Caldwell was an abuse of discretion. *Caldwell*, 287 F.3d at 1285-86.

The Fifth Circuit's requirement that Ellis prove she is unable to perform "each and every" material and substantial duty of her occupation to recover "own occupation" disability benefits under ERISA cannot be squared with the practical, common sense approach of the Second, Ninth and Tenth Circuits. Instead, the Fifth Circuit has adopted a construction of "Disability" that these Circuits have recognized is not wholly sensible or reasonable. This Court should review this case to address this conflict.

The Seventh, Tenth and Eleventh Circuits have also determined that "any occupation" provisions in ERISA disability insurance policies should not be construed so literally that an insured must be utterly helpless to be considered disabled, because such an overly restrictive construction would render the plan totally meaningless and severely undermine the purposes of ERISA. *Hammond v. Fidelity and Guaranty Life Insurance Company*, 965 F.2d 428, 431 (7th Cir. 1992); *Torix v. Ball Corporation*, 862 F.2d 1428, 1430-31 (10th Cir. 1988); *Helms v. Monsanto Company, Inc.*, 728 F.2d 1416, 1420 (11th Cir. 1984). Yet, in this case the Fifth Circuit has adopted an overly restrictive construction of the Liberty Life LTD policy that severely undermines the purposes of ERISA and is inconsistent with these decisions of the Seventh, Tenth and Eleventh Circuits.

Under the Fifth Circuit majority's construction of "Disability", virtually every person who is conscious and able to perform any single material duty of their job, such as sitting or speaking, is disqualified from recovering disability benefits under Liberty Life's policy. This result conflicts directly with the opinion in *Torix*, where the Tenth Circuit found that such a policy was totally meaningless and its coverage was wholly illusory, because an insured

could only be paid benefits if she had "no conscious life". 862 F.2d 1430-31.

Adding to this confounding milieu, the Fourth and Sixth Circuits have acknowledged constructions of "disability" that are similar to the Fifth Circuit's "each and every" construction in the context of "elimination periods" under an ERISA disability insurance policy issued by Reliance Standard Life Insurance Company. *Carr v. Reliance Standard Life Insurance Company*, 363 F.3d 604, 606-07 (6th Cir. 2004); *Gallagher v. Reliance Standard Life Insurance Company*, 305 F.3d 264, 270 (4th Cir. 2002). However, it is also clear an insured under the Reliance Standard Life Insurance disability policy qualifies for total disability benefits after the elimination period, if the insured is only able to perform some of the material duties of his/her occupation. *Carr*, 363 F.3d at 606. Thus, these "each and every" constructions of the Fourth and Sixth Circuits only serve to further demonstrate the inconsistency between the Circuits on this important issue.

There is also a conflict within the Fifth Circuit on this issue that is a microcosm of the conflict among the various Circuits. The "each and every" construction adopted by the Fifth Circuit majority in this case was previously rejected by other panels of the Fifth Circuit and that construction is contrary to the "fair and reasonable" construction other panels of the Fifth Circuit had previously given to similar "disability" provisions. *Lain v. Unum Life Insurance Company of America*, 279 F.3d 337, 344-45 (5th Cir. 2002), and *Vercher v. Alexander & Alexander, Inc.*, 379 F.3d 222, 228-29 (5th Cir. 2004). Neither *Lain* nor *Vercher* were even mentioned in the Fifth Circuit panel's majority opinion in this case.

In *Lain*, Unum terminated the insured's total disability income benefits using an "each and every" construction similar to the one adopted by the panel in this case. The panel in *Lain* found Unum's construction was "contrary to the plain language of the policy", and the "fair and reasonable" construction of that language only required an insured to prove she was unable to perform a single material duty of her occupation to qualify for total disability income benefits. *Lain*, 279 F.3d at 344-45.

In *Vercher*, another panel of the Fifth Circuit rejected a similar "any and every" construction, because that interpretation went too far. 379 F.3d at 228-29. The disability provision at issue in *Vercher*, provided total disability income benefits if the insured was "completely unable to perform any and every duty of your regular occupation". 379 F.3d at 224. The *Vercher* panel determined that if the insured could prove she was "unable to perform something that was indispensable or essential to the proper performance of her regular occupation", she was entitled to total disability income benefits. 379 F.3d at 231.

Finally, as part of its analysis regarding the proper "construction" of "Disability", the majority of the panel criticized the District Court for relying on the following deposition testimony of Liberty Life's litigation manager, Paula McGee:

> Q. Under that definition, if Ms. Ellis could not perform one of the material duties of her occupation, she would be disabled?
>
> A. Yes.

(App. A, *infra*, at p. 13a). The majority of the panel noted that in a post-deposition Affidavit, McGee explained she was confused by this deposition question and provided testimony that contradicted her deposition answer. (*Id.*). Amazingly, the majority of the panel concluded that this affidavit testimony trumped the deposition testimony and tipped the scale in favor of Liberty Life on the cross-motions for summary judgment.

It is well-recognized that a litigant is bound by answers given during a deposition, despite a later contradicting affidavit, unless there is an explanation for the contradiction, and then the post-deposition affidavit only creates at most an issue of fact. *Cleveland v. Policy Management Systems Corporation*, 526 U.S. 795, 806-07 (1999) (citing authority from every Circuit). Of course, the Fifth Circuit majority's incredible conclusion turns this established rule of law completely on its head.

The construction of "disability" in ERISA insurance policies is an issue of vital importance to the millions of Americans who purchase disability insurance coverage through their employers. Uniformity is vital to the purpose of ERISA. Thus, this Court's review of this case is necessary to resolve the foregoing conflicts between the Circuits and promote the uniformity of construction of disability insurance policies that ERISA requires.

B. The Fifth Circuit's "Each and Every" Construction is Also Contrary to the Plain Language of the Liberty Life LTD Policy.

In its majority opinion, the Fifth Circuit panel rejected the construction of the terms "unable to perform all of the material and substantial duties of his occupation" adopted by the District Court on the basis of the panel's conclusion such a construction rendered the definition of "Partial Disability" under the Liberty Life policy meaningless. (App. A, *infra*, at pp. 14a-16a). In reaching this conclusion, the majority of the Fifth Circuit panel ignored or misconstrued significant provisions of the Liberty Life LTD policy pertaining to "Partial Disability". As a consequence, the majority's construction of the Liberty Life LTD policy is also contrary to the plain language of the insurance policy, contrary to well-recognized rules of construction for ERISA insurance policies, and contrary to the reasonable expectations of Liberty Life's insured, Ellis.

It is well-recognized an ERISA insurance policy must be construed in accordance with its plain language, as a whole, giving meaning to all its parts. *Lifson v. INA Life Insurance Company of New York*, 333 F.3d 349, 353 (2d Cir. 2003); *McOsker v. Paul Revere Life Insurance Company*, 279 F.3d 586, 588 (8th Cir. 2001). Accordingly, the Fifth Circuit was obligated to construe the definition of "Disability" in Section 2 of the Liberty Life LTD policy in conjunction with all of the provisions of Section 4, Disability Income Benefits, not just the definition of "Partial Disability" that is in Section 4.

Contrary to the implied assumption made by the Fifth Circuit's majority, there are not two mutually exclusive classes of benefits under Section 4 of the Liberty Life LTD

policy. All benefits payable to an insured under Section 4 are a function of the "Disability Benefit". The "Disability Benefit" is the insured's benefit percentage multiplied by her earnings. This "Disability Benefit" is paid to insureds who are "Disabled". This "Disability Benefit" is also paid to "Partially Disabled" insureds who are unable to earn at least 20% of their Pre-Disability Earnings.[2] A "Partially Disabled" insured who is earning 20% or more of her Pre-Disability Earnings is paid the Loss of Earnings Monthly Benefit that is a percentage of the "Disability Benefit". Thus, there is no way an insured could qualify for both "Disability" and "Partial Disability" benefits, as the Fifth Circuit's panel majority erroneously assumed to justify its "each and every" construction.

Rather, the plain language of the policy indicates that the "unable to perform all" provisions for "Disability" and the "able to perform one or more, but not all" provisions of the definition of "Partial Disability" are complementary, if not synonymous. As an example, if an insured cannot do her job and has no earnings, because she can only perform three out of seven of the material duties of her occupation; the insured is entitled to the "Disability Benefit" under Section 4. The only way this insured can receive the "Disability Benefit" promised by Section 4, is that the phrase "unable to perform all" includes "able to perform one or more, but not all".

Yet, under the panel majority's construction, this employee does not qualify for the "Disability Benefit", because she is "Partially Disabled". However, as a "Partially

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[2] The First Circuit has acknowledged this construction of the QRP provisions of the Liberty Life LTD policy. *Cook v. Liberty Life Assurance Company of Boston*, 320 F.3d 11, 22 (1st Cir. 2003).

Disabled" insured with no earnings, she is clearly entitled to the "Disability Benefit" under Section 4 of the policy. The panel majority's construction of "Disability" cannot be squared with the plain language of Section 4, but the District Court's construction of "Disability" is entirely consistent with it.

Even if it is assumed the "each and every" construction adopted by the Fifth Circuit's majority was a reasonable construction, it is obvious there are two reasonable constructions of these provisions, as Judge Pickering concluded in his dissenting opinion. (App. A, *infra*, at p. 30a). When the provisions of an ERISA insurance policy have two reasonable, but conflicting constructions, the language is ambiguous. In such circumstances, it is well-recognized that the ambiguity must be construed against the ERISA insurer, and in favor of the reasonable expectations of the ERISA insured. *Lifson*, 333 F.3d at 353; *Bynum v. Cigna Healthcare of North Carolina*, 287 F.3d 305, 313 (4th Cir. 2002); *Lain*, 278 F.3d at 345; *Perez v. Aetna Life Insurance Company*, 150 F.3d 550, 556-57 (6th Cir. 1998); *McClure*, 84 F.3d at 1133-34. Yet, the majority of the Fifth Circuit panel ignored these established rules of construction pertaining to ERISA insurance policies and adopted a construction that was clearly contrary to the interests of the ERISA insured, Ellis.

In fact, the Fifth Circuit majority's construction actually renders the coverage of the Liberty Life LTD policy illusory. Using the majority's construction of "Disability", many insureds, who expect they will receive disability benefits when they are unable to perform their occupation, will actually be denied those benefits; unless the insureds can satisfy the insurmountable burden of proving a complete

inability to perform each and every material duty of their occupation, including duties such as sitting.

Because the Fifth Circuit has ignored the plain language of the Liberty Life LTD policy and ignored the established rules of construction under ERISA, this Court must review this matter to ensure the uniform construction of insurance policies that ERISA requires.

2. The Fifth Circuit's Rendition in Favor of Liberty Life Conflicts with the Abuse of Discretion Requirements Recognized by the Vast Majority of the Circuits and Is Contrary to this Court's Opinion in *Nord.*

Under the ERISA abuse of discretion standard of review, the vast majority of the Circuits recognize that an insurer's decision to deny or terminate disability benefits is an abuse of discretion, if it is not supported by substantial evidence in the administrative record. *Stup v. Unum Life Insurance Company of America*, 390 F.3d 301, 307-08 (4th Cir. 2004); *Kosiba v. Merck & Company*, 384 F.3d 58, 69 (3rd Cir. 2004); *Fought v. Unum Life Insurance Company*, 379 F.3d 997, 1014-15 (10th Cir. 2004); *McDonald v. Western-Southern Life Insurance Company*, 347 F.3d 161 169-70 (6th Cir. 2003); *Hawkins v. First Union Corporation Long-Term Disability Plan*, 326 F.3d 914, 919 (7th Cir. 2003); *Cook v. Liberty Life Assurance Company of Boston*, 320 F.3d 11, 19, 23 (1st Cir. 2003); *Caldwell v. Life Insurance Company of North America*, 287 F.3d 1276, 1282-83 (10th Cir. 2002); *Lain v. Unum Life Insurance Company of America*, 279 F.3d 337, 342 (5th Cir. 2002); *Levinson v. Reliance Standard Life Insurance Company*, 245 F.3d 1321, 1325-27 (11th Cir. 2001); *House v. The Paul Revere Life Insurance Company*, 241 F.3d 1045, 1048 (8th Cir. 2001); *Pinto v. Reliance Standard Life*

Insurance Company, 214 F.3d 377, 392 (3rd Cir. 2000); *Zavora v. Paul Revere Life Insurance Company*, 145 F.3d 1118, 1122-23 (9th Cir. 1998); *Woo v. Deluxe Corporation*, 144 F.3d 1157, 1162 (8th Cir. 1998); *Donaho v. FMC Corporation*, 74 F.3d 894, 899-900 (8th Cir. 1996).

Substantial evidence is more than a mere scintilla, it is relevant evidence of a quality and quantity that a reasonable mind would accept as adequate to support a conclusion. *McDonald*, 347 F.3d at 171; *Caldwell*, 287 F.3d at 1282; *House*, 241 F.3d at 1048; *Woo*, 144 F.3d at 1162; *Donaho*, 74 F.3d at 900, n.10. Mere scraps of evidence that might or might not support a denial, skewed interpretations of medical records, selective recall of portions of medical records, demands for more tests, statements of possibilities by insurer-retained reviewing physicians, and conclusions of insurer-retained physicians who are not specialists qualified to address the insured's particular illness or condition are not sufficient, especially when there is substantial, if not overwhelming, evidence supporting disability in the administrative record. *Stup*, 390 F.3d at 309; *Kosiba*, 384 F.3d at 68-69; *McDonald*, 347 F.3d at 170-71; *Hawkins*, 326 F.3d at 918-19; *Cook*, 320 F.3d at 23; *Caldwell*, 287 F.3d at 1284; *Levinson*, 245 F.3d at 1327; *House*, 241 F.3d at 1048; *Pinto*, 214 F.3d at 393-94; *Zavora*, 145 F.3d at 1123; *Woo*, 144 F.3d at 1162; *Donaho*, 74 F.3d at 901. This Court has also recently acknowledged that ERISA insurers may not refuse to credit an insured's reliable evidence of disability, including the opinions of the insured's treating physicians. *The Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003).

The abuse of discretion standard of review does not require abject or absolute deference to the ERISA insurer's

decision; it is not a rubber stamp of approval. *McDonald*, 347 F.3d at 172; *Hackett v. Xerox Corp. Long Term Disability Income Plan*, 315 F.3d 771, 774-75 (7th Cir. 2003); *Pinto*, 214 F.3d at 393. When an ERISA insurer determines eligibility and also pays the benefits out of its own assets, there is an inherent conflict of interest that decreases the deference accorded the ERISA insurer's decision. *Stup*, 390 F.3d at 307; *Fought*, 379 F.3d at 1003-04, 1006-07; *Caldwell*, 287 F.3d at 1282-83; *Levinson*, 245 F.3d at 1326; *Pinto*, 214 F.3d at 387-94; *Vega v. National Life Insurance Services, Inc.*, 188 F.3d 287, 297-99 (5th Cir. 1999); *Woo*, 144 F.3d at 1161-62. Under the "sliding scale" adopted by the majority of Circuits, this inherent conflict of interest increases the quality and quantity of evidence necessary to support the insurer's decision, as well as the scrutiny that is given to process leading to the insurer's decision. *Stup*, 390 F.3d at 307; *Caldwell*, 287 F.3d at 1282-83; *Pinto*, 214 F.3d at 393-94; *Vega*, 188 F.3d at 297-98; *Woo*, 144 F.3d at 1162.

In the context of a termination of disability benefits that an insurer has been paying to an insured, the Eighth Circuit has recognized the important focus should be on the events that occurred between the insurer's decision to pay the insured disability benefits and the insurer's decision to terminate those benefits, and unless the information provided to the insurer in that time frame alters in some significant way, the previous payment of benefits must weigh against terminating those benefits. *McOsker v. Paul Revere Life Insurance Company*, 279 F.3d 586, 590 (8th Cir. 2002).

The Sixth Circuit has also determined that a conflicted ERISA insurer abused its discretion when it terminated LTD benefits it was paying an insured, because there was no change in the medical evidence in the administrative record

that initially justified payment of the LTD benefits. *McDonald*, 347 F.3d at 163-64, 166, 169-73. In *McDonald*, the Sixth Circuit found a report of an insurer's retained psychiatrist that only raised the possibility of returning to work was not substantial evidence the insured was no longer disabled. 347 F.3d at 170-71.

In a case involving chronic fatigue syndrome and fibromyalgia, the First Circuit has held that Liberty Life abused its discretion when it terminated LTD benefits after paying them to an insured for over three years, because the medical evidence supplied by the insured's physician continued to show she remained disabled, as a consequence of fibromyalgia, and there was no credible contrary medical evidence in the administrative record that supported Liberty Life's termination of her LTD benefits.[3] *Cook*, 320 F.3d at 14, 16, 17, 21-23. In *Cook*, the First Circuit found that Liberty Life's about-face was not justified by its exaggeration of the significance of a confused communication of the insured's treating physician, an unjustified demand for "objective medical evidence", and its reliance on sketchy information of part-time work. 320 F.3d at 23.

In *Stup*, the Fourth Circuit held that a conflicted ERISA insurer must have more than tentative and ambiguous evidence that might or might not support its termination of disability benefits it had been paying to an insured. 390 F.3d

[3] The First Circuit also noted that Cook qualified for disability benefits from the Social Security Administration for her fibromyalgia just before Liberty Life terminated her LTD benefits. *Cook*, 320 F.3d at 16, n.5. As is reflected in the District Court's Supplement to Memorandum Opinion and Order, Ellis also began receiving SSA disability benefits shortly after Liberty Life denied her administrative appeal. (App. C, *infra*, at p. 49a).

at 309. The Fourth Circuit affirmed a district court's finding the insurer abused its discretion when it terminated LTD benefits it had been paying the insured for just over two years on the basis of an equivocal FCE that did not demonstrate the insured could perform sedentary work on an eight hour a day, five day a week basis. *Stup*, 390 F.3d at 309. The equivocal opinions of the physical therapist who performed the FCE and the insurer's in-house physician were not "substantial evidence" that supported termination of the LTD benefits. *Stup*, 390 F.3d at 309-11.

In another case involving fibromyalgia, the Third Circuit reversed a judgment approving a termination of LTD benefits an ERISA insurer had been paying to the insured for over three years. *Kosiba*, 384 F.3d at 61-63, 68-69. The evidence in the administrative record demonstrated considerable medical evidence from the insured's treating physicians that she remained disabled due to fibromyalgia, as well as a determination by the Social Security Administration that she was disabled on the basis of fibromyalgia. *Kosiba*, 384 F.3d at 68-69. The only contrary medical evidence was the report of a pulmonologist hired by the plan who did not address the insured's fibromyalgia and was not qualified to do so. *Id.*

In *Pinto*, the Third Circuit determined there was a fact issue whether a conflicted ERISA insurer abused its discretion when it terminated LTD benefits it was paying an insured, because there was: (1) no additional medical evidence supporting a reversal of its initial determination of disability; (2) the insurer selectively considered certain limitations from the treating cardiologist's records but disregarded his conclusions about disability; and (3) the insurer refused to accept a determination by the SSA the insured was disabled when it had used a previous SSA denial

as a basis for further investigation. 214 F.3d at 379-80, 393-94. In reversing the summary judgment granted in favor of the insurer, the Third Circuit remarked:

> First, Reliance Standard's reversal of its initial decision to grant benefits itself was questionable. Second, its final report credited the evidence favorable to the denial while inadequately explaining why it rejected the contrary evidence-the same evidence on the basis of which it had initially determined to award benefits.

Pinto, 214 F.3d at 379. This is practically the same criticism that Judge Pickering raised in his dissent concerning the deficiency in the panel majority's rendition of judgment in favor of Liberty Life. (App. A, *infra*, at pp. 31a-32a).

The Fifth Circuit's majority opinion clearly conflicts with the well-recognized substantial evidence requirement under the ERISA abuse of discretion standard of review. Despite a complete absence of credible evidence in the administrative record that Ellis could perform all of the material and substantial duties of her occupation, the panel of the Fifth Circuit summarily concluded Liberty Life's decision to terminate Ellis' LTD benefits eight months after it had begun paying them to her was not an abuse of discretion and rendered judgment in favor of Liberty Life.

The only support the panel cites in its majority opinion is a vague statement that Liberty Life "acquired subsequent medical evidence" after it had approved Ellis' entitlement to those LTD benefits. (App. A, *infra*, at p. 20a). The panel cites no specific evidence that supports the termination decision, and its silence can only be construed as an abject

deference that is certainly not permissible, given Liberty Life's admitted conflict of interest. (App. A, *infra*, at p. 12a).

However, as is detailed in the District Court's Memorandum Opinion and Order, there was "no credible, substantial, or positive evidence" in the administrative record that supported Liberty Life's abrupt about- face. Instead, the evidence in the administrative record from Drs. Hayes, Fujii, Matwijiw and Popovich all supported findings that Ellis suffered from an inflammatory myopathy, fibromyalgia, that resulted in chronic, severe musculoskeletal pain, fatigue, and cognitive impairments. This disease prevented Ellis from performing on the job driving, standing for any length of time, lifting more than 10 pounds on occasion, climbing, reaching, pulling, performing fine finger dexterity, or working an eight hour day. In fact, her condition was not improving but was getting progressively worse at the time her LTD benefits were terminated. (App. B, *infra*, at pp. 39a-41a, 47a).

The only other evidence in the administrative record came from the neurologist Liberty Life hired to examine Ellis, Dr. Croft. Dr. Croft was unsure of the specific diagnosis for Ellis' condition, it was possibly fibromyalgia or polymyocitis; and he did not address whether she could perform any duty of her occupation, except sitting. Indeed, he did not even state whether Ellis could perform any of the material or critical duties of her occupation, only that there was "insufficient evidence" that she could not perform a sedentary job. (App. B, *infra*, at p. 45a). Dr. Croft's "report" is hardly the quality or quantity of "substantial evidence" that is required in these circumstances by the vast majority of the Circuits, particularly the First, Third, Fourth, Sixth and Eighth Circuits.

The panel majority's vague reference to "subsequent medical evidence" also appears to allow Liberty Life to refuse to credit Ellis' considerable, if not overwhelming, reliable evidence of disability, contrary to this Court's admonition in *Nord*. Certainly, there is no discussion in the panel's majority opinion that gives any credit to the considerable medical evidence provided by Ellis' treating physicians or the factual information Ellis provided. Although the Social Security Administration gave this same evidence considerable weight in determining Ellis was disabled from any gainful employment, the majority of the Fifth Circuit panel apparently ignored it, just as Liberty Life did when it terminated Ellis' LTD benefits. Thus, there is no way the Fifth Circuit's rendition of judgment in favor of Liberty Life can be squared with *Nord*. This Court should also review this case to address this apparent disregard of its opinion regarding the ERISA abuse of discretion standard of review.

In reversing the District Court's judgment and rendering judgment for Liberty Life, the Fifth Circuit panel's majority ignores established federal law and renders an opinion that directly conflicts with the vast majority of the Circuits, particularly the First, Third, Fourth, Sixth and Eighth Circuits regarding the ERISA abuse of discretion standard of review. This rendition of judgment in favor of Liberty Life in these circumstances is also contrary to this Court's opinion in *Nord*. The ERISA abuse of discretion standard of review and its requirements are an important and recurring subject in ERISA benefits litigation. This Court should review this case to resolve the conflict between the established federal law on this subject and the Fifth Circuit's determination that Liberty Life is entitled to judgment, even though there is no substantial concrete evidence that supports its termination of Ellis' LTD benefits.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT FILED NOVEMBER 19, 2004

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 03-20623

LINDA ELLIS,

Plaintiff - Appellee - Cross-Appellant,

v.

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON,

Defendant - Appellant - Cross-Appellee.

Appeal from the United States District Court for the Southern District of Texas

Before JOLLY, WIENER, and PICKERING, Circuit Judges.*

WIENER, Circuit Judge:

Defendant-Appellant-Cross-Appellee Liberty Life Assurance Company of Boston ("Liberty") appeals the district court's denial of its motion for summary judgment and that court's grant of summary judgment in favor of plaintiff-appellee-cross-appellant Linda Ellis ("Ellis"). The

* Judge Pickering, whose dissent follows, participated in the original panel process before he resigned.

district court concluded that no genuine issue of material fact existed as to Ellis's claim under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq.*, and that she was entitled to summary judgment. The court ultimately ruled that Liberty in its role as plan fiduciary abused its discretion when it terminated Ellis's long-term disability ("LTD") benefits because substantial evidence did not demonstrate a change in her medical condition after Liberty initially determined that Ellis qualified for LTD benefits. The district court dismissed Ellis's state-law claims, however, holding that they are preempted by ERISA; and Ellis cross-appeals that ruling. For the reasons that follow, we (1) affirm the district court's dismissal of Ellis's state-law claims, (2) reverse the district court's grant of summary judgment and award of costs and fees in favor of Ellis, and (3) grant summary judgment in favor of Liberty, rendering a take-nothing judgment on Ellis's ERISA claim.

I. FACTS AND PROCEEDINGS

A. *The Policy*

Liberty is a nationwide insurance carrier that issued a disability insurance policy ("the Policy") to Chase Manhattan Bank ("Chase") in January 1997. The Policy, which is an integral part of an employee welfare benefits plan governed by ERISA, provides LTD benefits to eligible Chase employees.

The Policy specifies that LTD benefits are payable for the first 24 months of disability to a covered employee who is "*unable to perform all* of the material and substantial *duties*

of his occupation on an Active Employment basis because of an Injury or Sickness."[1] The Policy further provides that after 24 months, LTD benefits continue to be payable if the disabled employee "is unable to perform *with reasonable continuity,* all of the material and substantial *duties of his own or any other occupation* for which he is or becomes reasonably fitted by training, education, experience, age and physical and mental capacity."[2] As the plan fiduciary, Liberty is expressly vested with discretionary authority to make all coverage, eligibility, and interpretation decisions with regard to the Policy: "Liberty shall possess the authority, in its sole discretion, to construe the terms of this policy and to determine benefit eligibility hereunder."[3]

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1. Emphasis added.

2. Emphasis added.

3. Liberty urges that it is not the "plan administrator" as defined in 29 U.S.C. § 1002(16)(A), but the "claims administrator" or "claims fiduciary," as defined in 29 U.S.C. § 1105(c). Although our standard of review could hinge on which title is applicable to Liberty, independent research satisfies us that Liberty is a "fiduciary" as defined under 29 U.S.C. § 1002(21)(A) and thus entitled to the deferential "abuse of discretion" standard of review, irrespective of whether it is the plan administrator, claims administrator, or plan fiduciary.

Another thorough review of the plan reveals no specific designation of a "plan administrator." Chase, however, is specifically designated as the "plan sponsor." Thus, under the ERISA'S default provision, Chase is also the plan administrator. *See* 29 U.S.C. § 1002(16)(A)(ii) ("The term 'administrator' means . . . if an

(Cont'd)

Appendix A

B. *Ellis's Claim*

In 1997, Chase hired Ellis as a mortgage loan officer. Ellis worked at Chase until 1999, when she applied for short-term disability ("STD") benefits—under a different Liberty policy—because she could no longer perform her job duties as a loan officer. Although the exact nature of Ellis's medical condition remains somewhat unclear from the evidence in the record on appeal, her medical records indicate that she

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(Cont'd)
administrator is not so designated, the plan sponsor . . ."). Contrary to Liberty's assertion, though, we cannot conclude that it is the "claims administrator" under Section 1105(c) because in neither the plan nor any other document in the record does Chase expressly delegate any authority to Liberty (regrettably, the record does not contain *inter alia*, the Summary Plan Description). *See* 29 U.S.C. § 1105(c)(1) (stating that the plan may "expressly" provide for procedures allocating fiduciary responsibilities). Thus, without more, we would be required to review Liberty's interpretation of the plan *de novo*. *See, e.g., Rodriguez-Abreu v. Chase Manhattan Bank*, 986 F.2d 580, 584 (1st Cir. 1993) (holding that because there was no express delegation of fiduciary duty in plan documents to person or entity who made termination of benefits decision, district court correctly applied *de novo* standard of review); *Madden v. ITT Long Term Disability Plan*, 914 F.2d 1279, 1283- 84 (9th Cir. 1990) (same).

Nevertheless, we conclude—and there is no dispute—that Liberty is a "fiduciary" under 29 U.S.C. § 1002(21)(A) because Liberty is vested with "discretionary authority or discretionary responsibility in the administration of [the] plan." *See* 29 U.S.C. § 1002(21)(A)(iii). Accordingly, because Liberty is a fiduciary that the plan vests with discretionary authority, we review Liberty's determinations under the abuse of discretion standard. *See Baker v. Metro. Life Ins. Co.*, 364 F.3d 624, 629-30 & n.12 (5th Cir. 2004).

might suffer from fibromyalgia, a rheumatic syndrome that causes pain in muscles, tendons, and fibrous and other connective tissues. Liberty reviewed Ellis's STD claim, approved it, and started paying her STD benefits in January 2000.[4]

When Ellis's STD benefits expired later that year, her claim automatically converted into one for LTD benefits under the Policy. Liberty then began to investigate whether Ellis's claim fell within the Policy's definition of LTD. In June 2000, Liberty informed Ellis by letter that it had reviewed her file and determined that she was eligible for LTD benefits. Liberty also informed Ellis that it would periodically require updated medical information "to support total disability as defined by the Policy." Liberty continued its investigation, and, in light of additional medical evidence that it subsequently gathered, Liberty determined that Ellis was not eligible for LTD benefits. In December, Liberty wrote to Ellis:

> While it is apparent you were ill and met the criteria for your policy's definition of disability initially, based on the medical information received, you no longer meet your Long Term Disability Policy's definition of disability. Therefore, we must close your claim for benefits, effective December 31, 2000.

The following month, Ellis administratively appealed Liberty's decision to terminate her LTD benefits. Ellis

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4. Liberty's grant of STD benefits to Ellis for the maximum period of six months is not before us on appeal.

submitted further medical information to Liberty, which forwarded her file to its Managed Disability Services Unit ("MDSU"). The MDSU concluded that no objective medical findings existed that would render Ellis "disabled" within the contemplation of the Policy. Liberty then affirmed its decision to terminate Ellis's LTD benefits. (Liberty has made no effort, however, to recoup the LTD benefits previously paid to Ellis.)

In October, Ellis sued Liberty in Harris County, Texas. Ellis asserted Texas statutory and common law claims for violations of the state insurance code, breach of contract, and breach of the duty of good faith and fair dealing. Liberty timely removed the suit to the district court pursuant to 28 U.S.C. § 1441(b) on the basis of ERISA preemption.

The following fall, after the close of discovery, Liberty filed a motion for summary judgment seeking dismissal of Ellis's state-law claims. In response, Ellis filed a cross-motion for summary judgment and sought to amend her complaint to state an ERISA claim. The district court granted Ellis leave to amend her complaint, and Liberty filed a supplemental motion for summary judgment to dismiss her ERISA claim.

The district court eventually denied Liberty's motion for summary judgment and granted summary judgment to Ellis on her ERISA claim. The court dismissed Ellis's state-law claims, however, holding that they were preempted by ERISA. The district court subsequently issued a supplemental memorandum and order clarifying its award of attorneys' fees and prejudgment interest to Ellis, ultimately entering final judgment in favor of Ellis.

Two days later, Ellis filed a motion to alter or amend the judgment on the amount of damages, attorneys' fees, and prejudgment interest. The district court granted the motion in part, increasing the quantum of Ellis's future disability benefits and clarifying the rate of prejudgment interest. Liberty timely filed its notice of appeal.[5]

II. ANALYSIS

A. *Leave to Amend Complaint*

Liberty first argues that the district court erred when it granted Ellis leave to amend her complaint to state an ERISA claim. We review a district court's decision to grant leave to amend a complaint for abuse of discretion.[6] Federal Rule of Civil Procedure 15 states that leave to amend pleadings "shall be freely given when justice so requires."[7] In determining whether to grant leave, a district court may consider such factors as (1) undue delay; (2) bad faith; (3) dilatory motive on the part of the movant; (4) repeated failure to cure deficiencies by any previously allowed amendment; (5) undue

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5. On June 16, 2003, Liberty had prematurely appealed the district court's order of June 3, 2003, which granted Ellis's motion for summary judgment. The parties do not dispute that we have jurisdiction because the appeal is now timely. *See* Fed. R.App. P. 4(a)(2) ("A notice of appeal filed after the court announces a decision or order—but before the entry of the judgment or order—is treated as filed on the date of and after the entry.").

6. *Wimm v. Jack Eckerd Corp.*, 3 F.3d 137, 139 (5th Cir.1993).

7. Fed.R.Civ.P. 15.

prejudice to the opposing party; and (6) futility of amendment.[8] Although the district court assigned no reasons on the record for granting Ellis leave to amend her complaint, we are satisfied that it did not abuse its discretion when it did so.

Although Liberty argues that Ellis's amendment demonstrates undue delay, bad faith, and dilatory motive, we find no evidence in the record to support such an argument. Liberty's strongest argument concerns the potential prejudice that it may have suffered as a result of Ellis's filing of her amendment so late in the proceedings in district court. We reject this argument. Liberty removed Ellis's state-court suit on the basis of ERISA preemption. Ultimately, and as Liberty argued in its Notice of Removal, the district court concluded that ERISA preempted all of Ellis's state-law claims.[9] We have previously held that "ERISA's preemptive and civil enforcement provisions operate to 'recharacterize' such claims into actions arising under federal law."[10] Thus, for removal purposes, ERISA's preemptive power recharacterized Ellis's state-law breach of contract claim as a claim arising under federal law, specifically ERISA. Liberty might not have known with certainty that Ellis's breach of

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8. *Wimm*, 3 F.3d at 139.

9. It is unclear whether the district court ruled that ERISA preempted Ellis's state-law claims through complete or conflict preemption. Here, we assume that the district court found that ERISA completely preempted only Ellis's breach of contract claim for removal purposes. *See infra*, note 26.

10. *Degan v. Ford Motor Co.*, 869 F.2d 889, 893 (5th Cir.1989).

contract claim would be recharacterized as an ERISA claim and that Liberty would ultimately have to litigate such a claim. Having removed on the basis of ERISA preemption, however, Liberty cannot now be heard to complain about the district court's grant of leave for Ellis to amend her complaint to include an ERISA claim. There was no prejudice to Liberty, and the district court did not abuse its discretion when it granted Ellis leave to amend her complaint to state an ERISA claim.

B. *ERISA Claim*

1. Standard of Review

We review a district court's grant of summary judgment *de novo*.[11] "Whether the district court employed the appropriate standard in reviewing an eligibility determination made by an ERISA plan administrator is a question of law."[12] We thus review this decision *de novo*.[13] When the ERISA plan vests the fiduciary with discretionary authority to determine eligibility for benefits under the plan or to interpret the plan's provisions, "our standard of review is abuse of discretion."[14] As the Policy vests Liberty, as plan fiduciary,

11. *Tolson v. Avondale Indus., Inc.*, 141 F.3d 604, 608 (5th Cir.1998) (citing *FDIC v. Myers*, 955 F.2d 348, 349 (5th Cir.1992)).

12. *Lynd v. Reliance Standard Life Ins. Co.*, 94 F.3d 979, 980-81 (5th Cir.1996) (citing *Chevron Chem. Co. v. Oil, Chem. & Atomic Workers Local Union 4-447*, 47 F.3d 139, 142 (5th Cir.1995)).

13. *See id.* at 981.

14. *Tolson*, 141 F.3d at 608.

with the "sole discretion" to construe the terms of and to award benefits under the Policy, we review Liberty's interpretation of the Policy for abuse of discretion.[15]

2. Plan Interpretation

We have previously explained in detail the appropriate two-step process to review a plan fiduciary's interpretation of its plan:

> First, a court must determine the legally correct interpretation of the plan. If the administrator did not give the plan the legally correct interpretation, the court must then determine whether the administrator's decision was an abuse of discretion. In answering the first question, i.e., whether the administrator's interpretation of the plan was legally correct, a court must consider:
>
> (1) whether the administrator has given the plan a uniform construction,
>
> (2) whether the interpretation is consistent with a fair reading of the plan, and

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15. When the ERISA plan fiduciary is vested with discretionary authority under the plan, our standard of review is the same as if the fiduciary were the plan administrator under 29 U.S.C. § 1002. *See, e.g.*, *Estate of Bratton v. Nat'l Union Fire Ins Co. of Pittsburgh*, 215 F.3d 516, 520-21 (5th Cir. 200) (noting that same standard of review applies to plan administrators and fiduciaries).

> (3) any unanticipated costs resulting from different interpretations of the plan.[16]

If we determine that the fiduciary's interpretation of the plan was legally correct, the inquiry is over, pretermitting any need to consider whether a legally incorrect interpretation of the fiduciary was not an abuse of discretion.[17]

We have also held that when a complaining participant or beneficiary shows that the plan fiduciary has a conflict of interest, we apply a sliding scale to the *Wildbur* standard: "The greater the evidence of conflict on the part of the administrator, the less deferential our abuse of discretion standard will be."[18] "The degree to which a court must abrogate its deference to the administrator depends on the

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16. *Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 637-38 (5th Cir.), *modified*, 979 F.2d 1013 (1992).

17. *See id.; see also Tolson*, 141 F.3d at 608 ("A determination that a plan administrator's interpretation is legally correct pretermits the possibility of abuse of discretion.").

18. *Vega v. National Life Ins. Servs., Inc.*, 188 F.3d 287, 297 (5th Cir.1999) (en banc) (discussing *Wildbur*).

Unlike the dissent, we will not read into *Vega* a presumption that a conflict exists *ipso facto* merely because the plan fiduciary both insures the plan and administers it. *See MacLachlan v. ExxonMobil Corp.*, 350 F.3d 472, 479 n. 8 (5th Cir.2003). That an ERISA plaintiff must come forward with evidence that a conflict exists—and that any reduction in the degree of our deference depends on such evidence—belies any duty on our part to make such an assumption. *See id.*

extent to which the challenging party has succeeded in substantiating its claims that there is a conflict."[19] In its Objections and Responses to Plaintiff's Request for Admissions, Liberty acknowledges that it has a financial interest in the dollar value of the claims that are paid under the Policy. This is enough to satisfy us that a legal conflict of interest exists here. Accordingly, we apply the sliding-scale standard of review articulated in *Vega* to Liberty's interpretation of its Policy provision.

As noted above, the LTD Policy provides that benefits are initially payable only to an employee who is "unable to perform *all* of the material and substantial *duties of his occupation* on an Active Employment basis because of an Injury or Sickness."[20] The district court concluded that, under this language, Ellis would be eligible to receive LTD benefits if she "could not perform *any one* of the material duties of her occupation."[21]

The district court erred when it interpreted the phrase "unable to perform *all*"—the language in the policy—as synonymous with "unable to perform *any one*." We interpret "unable to perform all" as synonymous with "not able to perform every." In other words, "unable" is synonymous with "not able," and "all" is synonymous with "every." Applying the *Wildbur* methodology, we hold that Liberty gave a legally correct interpretation to this provision of the plan.

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19. *MacLachlan*, 350 F.3d at 479.

20. Emphasis added.

21. Emphasis added.

Appendix A

The first *Wildbur* factor—whether the fiduciary has given the plan a uniform construction—weighs in favor of Liberty's interpretation. The district court mistakenly relied solely on the deposition testimony of Liberty's litigation manager, Paula McGee, as support for crediting Ellis's proffered interpretation that she is entitled to LTD benefits if she is unable to perform "any one" of the material and substantial duties of her occupation. McGee testified:

> Q. Under that definition, if Ms. Ellis could not perform one of the material duties of her occupation, she would be disabled?
>
> A. Yes.

In a subsequent affidavit, however, McGee explained that counsel's question at the deposition confused her and that the company had consistently interpreted "Disability" to mean a person who is unable—not able—to perform all—each and every one—of the material and substantial duties of her own occupation:

> Liberty has consistently interpreted the Policy. Specifically, when evidence reveals that during the first 24 months of disability, an employee is capable of performing the material and substantial duties of her own occupation, the Company has denied benefits. In my five years of employment with Liberty, I cannot recall an instance where this Policy provision was interpreted differently.

Appendix A

McGee's post-deposition affidavit is buttressed by the testimony of Liberty's disability claims consultant and its appeals consultant. Both testified in depositions that Liberty decided to terminate Ellis's benefits by virtue of its interpretation that a disabled person under the LTD Policy is a person who is not able to perform every material and substantial duty of her occupation. All this tips the scale in favor of Liberty on the first *Wildbur* factor.

The next *Wildbur* factor—whether Liberty's interpretation is "consistent with a fair reading of the plan"—also supports Liberty's interpretation. For Ellis to qualify for LTD benefits under the Policy, Liberty determined that she had to show that she could not perform "each" of the material and substantial duties of her occupation; in other words, "each and every duty" or "every single duty." This is consistent with a fair reading of the plain wording of the plan. There is no dispute that the Policy language requires that Ellis be unable to perform *all* of the material and substantial duties of her occupation to receive LTD benefits. We conclude that in the context of the Policy as a whole, a fair reading of the term "unable to perform all" is that Ellis is *not* disabled for purposes of LTD if she *can* perform "at least one" of the material and substantial duties of her occupation. Ellis's proffered interpretation, that she *is* disabled if she *cannot* perform one ("any one") of the material and substantial duties of her occupation—i.e., "unable to perform all" means "not able to perform any one"—cannot be squared with the Policy's language.

Our conclusion that Liberty's interpretation is legally correct is strengthened by consideration of the third *Wildbur*

factor—whether a different interpretation of the plan would result in unanticipated costs to the plan. A comparison of the Policy provisions that define "Disability" and "Partial Disability" *in pari materia* leads inescapably to the conclusion that adoption of Ellis's proffered interpretation would lead to Liberty's incurring of unanticipated costs. Section 4 of the Policy defines *Partial* Disability:

> "Partial Disability" or "Partially Disabled" means as a result of the Injury or Sickness, the Covered Person is: 1. able to perform *one or more, but not all,* of the material and substantial duties of his own or any other occupation on an Active Employment or a part-time basis . . .[22]

Liberty reasons with irrefutable logic that if we were to credit Ellis's interpretation of "Disability," the definitions of "Disability" and "Partial Disability" would conflate these separate categories into one, i.e., there would be no difference between the eligibility prerequisites for *total* disability and those for *partial* disability. It follows that if that were the case, Liberty would be required to provide both LTD and partial disability benefits to a covered employee if he could not perform "any one" of the material and substantial duties of his occupation, a patently absurd result. If the definition of long term disability were interpreted to mean "unable to perform just one," as Ellis urges, "unable to perform all" in the definition of *Disability* would be synonymous with "unable to perform one or more" in the definition of *Partial Disability*. That simply cannot be: Such a reading would

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22. Emphasis added.

render partial disability's phrase "but not all" meaningless surplusage, not to mention putting it in direct conflict with Ellis's proffered interpretation of "all" in the phrase "unable to perform all" in the definition of Disability. Obviously, this cannot be the intended result under the Policy and—just as obviously—unanticipated costs would be incurred by Liberty.

Ellis attempts to counter by asserting that Liberty's interpretation is legally incorrect because "[u]nder this contorted interpretation, virtually no person could ever satisfy the definition of 'Disability.'" Ellis offers the example of a secretary who is rendered paraplegic, contending that this employee would not be disabled under Liberty's interpretation if she could sit at her desk in a wheelchair and answer a speaker phone. Ellis's argument ignores, however, the two adjectives that modify "duties"—"material and substantial." Merely because a disabled employee can perform a minor, collateral duty of his job, e.g., answering a speaker phone, would not justify the plan fiduciary's considering such an employee ineligible for benefits under Liberty's interpretation of the LTD Policy. In such a situation, the disabled employee *would be* disabled under Liberty's interpretation, despite his ability to perform minor duties, as long as he could not—was "unable to"—perform any of the *material and substantial* duties of his occupation. We conclude that Ellis would have to demonstrate that she cannot perform "every single" or "each and every" "material and substantial duty of her occupation"—which she could not

prove—to obtain LTD benefits. Liberty gave a legally correct interpretation of the plan provision in question.[23]

Among the rest of Ellis's arguments, we perceive that two merit brief consideration. The first concerns the burden of proof under ERISA. Ellis insists that substantial record

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23. Even if we were to assume, *arguendo,* that Liberty, as a plan fiduciary with a *Vega* conflict, was not legally correct, we would hold that Liberty did not abuse its discretion vested by the Policy, and that Ellis could not recover. To determine whether the plan fiduciary abused its discretion, we consider: (1) the internal consistency of the plan under the fiduciary's interpretation; (2) any appropriate regulations formulated by the appropriate administrative agencies; and (3) the factual background of the determination and any inferences of lack of good faith. *Wildbur,* 974 F.2d at 638.

The first *Wildbur* factor for determining abuse of discretion—the internal consistency of the plan under the plan fiduciary's interpretation—weighs in favor of Liberty's interpretation, as our discussion on the relationship between "Disability" and "Partial Disability" demonstrates. Adoption of Ellis's proffered interpretation would render the language in the "Partial Disability" provision superfluous and inconsistent with that in the "Disability" provision. The second *Wildbur* factor—any relevant administrative agency regulations—is neutral as we have found none that apply here. The third *Wildbur* factor also weighs in favor of Liberty. Although Ellis may urge that Liberty made its decision in bad faith, the fact that Liberty initially granted her LTD benefits under the Policy supports a finding of good faith on Liberty's part. Further, as we note below, merely because Liberty initially granted Ellis benefits, it is not estopped from terminating those benefits when substantial evidence supports its decision. A careful and thorough review of the administrative record eschews a conclusion of abuse of discretion in Liberty's decision to terminate Ellis's benefits.

evidence supports her claim of total disability, in light of which Liberty abused its discretion when it determined that she was not disabled. This argument misapprehends the burden of proof under ERISA. The law requires only that substantial evidence support a plan fiduciary's decisions, including those to deny or to terminate benefits, *not* that substantial evidence (or, for that matter, even a preponderance) exists to support the employee's claim of disability.[24] Substantial evidence is "more than a scintilla, less than a preponderance, and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."[25] We are aware of no law that requires a district court to rule in favor of an ERISA plaintiff merely because he has supported his claim with substantial evidence, or even with a preponderance. If the plan fiduciary's decision is supported by substantial evidence and is not arbitrary and capricious, it must prevail.

The second argument that we address is more problematic, as it tangentially concerns the degree or level of proof that is needed to sustain a plan fiduciary's interpretation of its policy provision. The crux of the dispute here is whether—as Ellis contends and the district court

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24. *See, e.g., Meditrust Fin. Servs. Corp. v. Sterling Chem., Inc.*, 168 F.3d 211, 215 (5th Cir.1999) ("When reviewing for arbitrary and capricious actions resulting in an abuse of discretion, we affirm an administrator's decision if it is supported by substantial evidence.").

25. *Deters v. Secretary of Health, Educ. & Welfare*, 789 F.2d 1181, 1185 (5th Cir.1986) (citing *Richardson v. Perales*, 402 U.S. 389, 401 (1971)).

ruled—a plan fiduciary's decision to terminate LTD benefits once it has initially agreed to provide them must be supported by evidence that a substantial change in the covered employee's medical condition occurred *after* the initial grant of benefits. The parties dispute whether a higher standard of proof is required to sustain a plan fiduciary's decision to *terminate* benefits once granted than is needed to sustain a plan fiduciary's *initial denial* of benefits. Ellis argues that because Liberty initially determined that she qualified for LTD benefits, it abused its discretion when it terminated her LTD benefits months later, without medical evidence reflecting that a substantial change in her condition had occurred in the interim. The district court accepted Ellis's evidentiary dichotomy and ruled that the absence of credible, substantial, or positive evidence in the record to demonstrate that Ellis had become medically ineligible for permanent disability benefits *after* having been found eligible initially precluded Liberty from terminating the benefits previously granted.[26]

We disagree with the district court's view of the applicable law. We have found no statutory, regulatory, or jurisprudential authority—and neither Ellis nor the district court has cited any to us—that would heighten the level of the proof needed for a plan fiduciary to determine entitlement or non-entitlement to LTD benefits simply because the fiduciary previously had approved entitlement and paid benefits to the employee in question. The district court committed legal error when it concluded that, once the

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26. We note that the district court still reviewed Liberty's interpretation of the LTD Policy provisions for abuse of discretion.

fiduciary approves entitlement to LTD benefits, subsequent termination of those benefits would have to be supported by substantial evidence of a *change in the employee's condition.* We have never articulated such an evidentiary distinction or imposed such a requirement on the plan fiduciary: All that ERISA requires is that substantial evidence support a plan fiduciary's benefits decision—whether it be to deny benefits initially or to terminate benefits previously granted—when, as here, the plan fiduciary is vested with the discretion to determine, *inter alia,* both initial and continued eligibility for benefits. In the investigation that continued following its initial grant of LTD benefits to Ellis, Liberty acquired subsequent medical evidence that supported termination of her LTD benefits months *after* it had approved Ellis's entitlement to them on the basis of the evidence that it had before it at that time.

We hold that when a plan fiduciary initially determines that a covered employee is eligible for benefits and later determines that the employee is not, *or has ceased to be,* eligible for those benefits by virtue of additional medical information received, the plan fiduciary is not required to obtain proof that a substantial change in the LTD recipient's medical condition occurred *after* the initial determination of eligibility. Indeed, evidence could exist—as it did here—at the time that the plan fiduciary initially granted benefits that demonstrates that the ERISA plaintiff is not totally disabled. In addition, a plan fiduciary could receive evidence that an ERISA plaintiff is not totally disabled months after it has made the initial grant of benefits. A contrary holding would basically prohibit a plan fiduciary from ever terminating benefits if it later discovered evidence that the ERISA

plaintiff was not disabled at the time of the initial grant of benefits.[27] More importantly to plan participants and beneficiaries, such a rule would have a chilling effect on the promptness of granting initial benefits in the first place. This we are unwilling to do. A plan fiduciary that has granted plan benefits to a participant or beneficiary is not estopped from terminating those benefits merely because there is no evidence that a substantial change in the covered employee's medical condition occurred after the original grant of benefits.

3. Attorneys' Fees and Costs

As we reverse the district court's grant of summary judgment in favor of Ellis, we vacate the award of costs and attorneys' fees to Ellis.

4. Preemption

Ellis cross-appeals the district court's ruling that ERISA preempts her state-law claims. She sued Liberty for violations of Texas Insurance Code ("TIC") articles 21.21 and 21.55 and for breaches of the common law duty of good faith and fair dealing. TIC article 21.21 prohibits unfair competition and unfair practices by insurance companies and subjects them to civil liability for violations.[28] TIC article 21.55 subjects insurance companies to civil liability if they unfairly

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27. This is especially true in a case such as this, where some of the evidence on which Liberty relied to deny LTD benefits to Ellis arose in May and June 2000, before it initially granted her LTD benefits.

28. *See* TEX. INS. CODE § 21.21.

and untimely process and treat a claim.[29] With respect to Ellis's common-law claim, the courts of Texas have held that "[a] cause of action for breach of the duty of good faith and fair dealing is stated when it is alleged that there is no reasonable basis for denial of a claim or delay in payment or a failure on the part of the insurer to determine whether there is any reasonable basis for the denial or delay."[30] Ellis argues that the United States Supreme Court's holding in *Kentucky Association of Health Plans, Inc. v. Miller*[31] brings her claims under ERISA's savings clause.[32] We review ERISA preemption of state law *de novo*.[33]

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29. *See* TEX. INS. CODE § 21.55.

30. *Arnold v. Nat'l County Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex.1987).

31. 538 U.S. 329, 341-42 (2003).

32. 29 U.S.C. § 1144(b)(2)(B) ("Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.").

33. *Provident Life & Accident Ins. Co. v. Sharpless*, 364 F.3d 634, 640 (5th Cir.2004).

Under conflict preemption,[34] ERISA preempts state laws "insofar as they may now or hereafter relate to any employee

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34. There are two types of preemption under ERISA. ERISA may occupy a particular field, which results in complete preemption under 29 U.S.C. § 1132(a). *See Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. 58, 66 (1987). "Section 502 [1132(a)], by providing a civil enforcement cause of action, completely preempts any state cause of action seeking the same relief, regardless of how artfully pleaded as a state action." *Giles v. NYLCare Health Plans, Inc.,* 172 F.3d 332, 337 (5th Cir.1999). Complete preemption permits removal to federal court because the cause of action arises under federal law. *See id.* The parties do not dispute, and the district court properly concluded, that for purposes of removal, Ellis's state law breach of contract claim arose under federal law because it is one for the recovery of benefits under Section 1132(a). *See Arana v. Ochsner Health Plan,* 338 F.3d 433, 438 (5th Cir.2003) (en banc) (noting that a claim "to recover benefits . . . under the terms of [a] plan" or a claim "to enforce . . . rights under the terms of [a] plan" is completely preempted under Section 1132(a)). Accordingly, the district court properly exercised supplemental jurisdiction over Ellis's remaining state-law claims under 28 U.S.C. § 1367. *See Darcangelo v. Verizon Communications, Inc.,* 292 F.3d 181, 187 (4th Cir.2002).

In contrast, ERISA preempts a state law action under 29 U.S.C. § 1144(a) when it conflicts with the state law. *Bullock v. Equitable Life Assur. Soc. of U.S.,* 259 F.3d 395, 399 (5th Cir.2001). Conflict preemption does not allow removal to federal court but is an affirmative defense against claims that are not completely preempted under Section 1132(a). *Giles,* 172 F.3d at 337. We assume for purposes of this appeal, and because the parties dispute *Miller*'s applicability to the claims here, that the district court found that Ellis's three remaining state-law claims were preempted under Section 1144(a), ERISA's conflict preemption provision. We therefore do not consider whether Section 1132(a) *completely* preempts Ellis's state-law claims.

benefit plan."[35] As an exception, however, ERISA's so-called savings clause allows state laws "which regulate insurance, banking, or securities" to survive ERISA preemption.[36] In *Miller,* the Supreme Court simplified the test for ERISA conflict preemption when it made a clean break with the McCarran-Ferguson factors that it traditionally applied to determine whether a state statute regulated insurance and thus survived preemption under ERISA's saving clause.[37] After *Miller,* for a state law to be deemed a "law . . . which regulates insurance" under Section 1144(b)(2)(A) and thus be exempt from traditional ERISA preemption, such law must (1) be directed toward entities engaged in insurance, and (2) substantially affect the risk pooling arrangement between the insurer and the insured.[38]

On the one occasion that we considered *Miller*'s change to ERISA preemption, we observed that "[t]he only pertinent difference between the *Miller* analysis and the previous test is that in place of the second *Miller* inquiry, the previous test asked whether the statute in question 'transfers or spreads

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35. 29 U.S.C. § 1144(a).

36. *Id.* § 1144(b)(2)(A).

37. 538 U.S. at 339. Under the McCarran-Ferguson factors, the Court considered whether (1) the practice had the effect of transferring or spreading a policyholder's risk; (2) the practice is an integral part of the policy relationship between the insured and the insurer; and (3) whether the practice is limited to entities within the insurance industry. *See id.*

38. *Id.* at 341-42.

the risk from the insured to the insurer.'"[39] Also, prior to *Miller,* we held that ERISA preempts TIC articles 21.21[40] and 21.55[41] well as the Texas common law duties of good faith and fair dealing.[42] Thus, we need only answer whether the "simplified" *Miller* analysis affects our prior holdings. We conclude that it does not with respect to Ellis's state-law claims. Thus, ERISA preempts Ellis's common law claim for breach of the duties of good faith and fair dealing. Specifically, this common law doctrine fails the first prong of the *Miller* analysis because it is not directed toward entities engaged in insurance.[43]

Regarding Ellis's two statutory claims, Liberty contends that TIC articles 21.21 and 21.55 likewise fail the first prong of the *Miller* analysis because they address the misconduct of insurers and thus do not regulate insurance. This argument misses the mark. As the Supreme Court noted in *Rush Prudential v. Moran,* to determine whether a law "regulates insurance," "we start with a 'common-sense view of the

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39. *Sharpless,* 364 F.3d at 640.

40. *Hogan v. Kraft Foods,* 969 F.2d 142, 144-45 (5th Cir.1992) (and cases cited therein).

41. *McNeil v. Time Ins. Co.,* 205 F.3d 179, 191-92 (5th Cir.2000).

42. *Hogan,* 969 F.2d at 144-45 (and cases cited therein).

43. *See Miller,* 538 U.S. at 334, 123 S.Ct. 1471 ("[L]aws of general application that have some bearing on insurers do not qualify.").

matter,' . . . under which 'a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry.'"[44] In *Moran,* the Supreme Court went on to hold that "when insurers are regulated with respect to their insurance practices, the state law survives ERISA."[45] In *Sharpless,* we analyzed the effect of the *Miller* decision on our ERISA preemption analysis, noting that *Miller* had not changed this factor.[46] Indeed, whereas the McCarran-Ferguson analysis required that we determine whether the practice "is limited to *entities* within the insurance industry,"[47] the *Miller* analysis merely requires that we determine whether the "statute is specifically directed towards *entities* engaged in insurance."[48] TIC articles 21.21 and 21.55 are undeniably directed toward *entities* engaged in insurance, as they regulate any possible unfair practices and expose the insurer to civil liability for violations of the statutes. We are satisfied therefore that articles 21.21 and 21.55 satisfy the first prong of the *Miller* analysis.

To survive ERISA preemption, however, TIC articles 21.21 and 21.55 must also satisfy *Miller*'s second prong; they must "substantially affect the risk pooling arrangement

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44. 536 U.S. 355, 365-66 (2002) (quoting *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 50 (1999)).

45. *Id.* at 366.

46. 364 F.3d at 640.

47. *Id.* at 640 n. 4 (emphasis added).

48. *Id.* at 640 (emphasis added).

between the insurer and the insured."[49] We hold that these two articles do not.

In *Miller,* the Supreme Court explained that, to affect the risk-pooling arrangement, a statute must "alter the scope of permissible bargains between insurers and insureds" and thus substantially affect the risk-pooling "arrangements that insurers may offer."[50] TIC articles 21.21 and 21.55 are remedial in nature—they provide remedies "to which the insured may turn when injured by the bad faith of the insurer."[51] Being remedial, these two articles cannot possibly affect the *bargain* that an insurer makes with its insured *ab initio.* They provide only that "whatever the bargain struck," the insured may recover additional damages if thereafter the insurer acts in bad faith or unfairly.[52] As TIC articles 21.21 and 21.55 provide remedies above and beyond those provided in ERISA, they are remedial in nature and do not affect the

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49. 538 U.S. at 342.

50. 538 U.S. at 338-39.

51. *Barber v. Unum Life Ins. Co. of Am.,* 383 F.3d 134, 143 (3d Cir.2004).

52. *See id.* at 143; *see also Pilot Life,* 481 U.S. at 49-51 (holding that "the common law of bad faith does not define the terms of the relationship between the insurer and the insured; it declares only that, whatever terms have been agreed upon in the insurance contract may in certain circumstances allow the policyholder to recover punitive damages").

risk—here, the covered employee's disability—for which the insured contracted with the insurer.[53]

Within the insurance industry, "risk" signifies "the risk of occurrence or injury or loss for which the insurer contractually agrees to compensate the insured."[54] Here, the risk pooled is that of long-term disability, and this risk is reflected in the terms of the Policy itself. The remedies that TIC articles 21.21 and 21.55 provide for unfair practices and bad faith are not risks identified in the Policy as a risk of loss that Liberty agrees to bear for Chase or for Ellis and other similarly situated Chase employees. As a basic tenet of insurance law, the insurance policy "defines the scope of risk assumed by the insurer from the insured."[55] Here, Liberty did not contract with Chase or Ellis to assume the risk of any unfair practices or bad faith violations. As TIC articles 21.21 and 21.55 fail *Miller*'s second prong, Ellis's claims grounded in violations of those articles are preempted by ERISA.

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53. *See, e.g.*, TEX. INS. CODE § 21.21(16)(b)(1) (providing treble damages for violations of article 21.21); *Stewart Title Guaranty Co. v. Sterling*, 822 S.W.2d 1, 9 (Tex.1991) (noting that treble damages under article 21.21 are punitive in nature).

Article 21.55 also provides a statutory penalty of 18% interest for an insurance company's failure to comply with its provision. *See Evergreen Nat'l Indem. Co. v. Tan It All, Inc.*, 111 S.W.3d 669, 678 (Tex.App.2003).

54. *Barber*, 383 F.3d at 143.

55. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 131 (1982).

III. CONCLUSION

We affirm the district court's dismissal of Ellis's state-law claims and that court's grant of leave to Ellis to amend her complaint. We reverse the district court's grant of summary judgment and award of costs and fees in favor of Ellis, and we grant summary judgment in favor of Liberty, rendering a take-nothing judgment against Ellis on her ERISA claim.

AFFIRMED IN PART, REVERSED AND RENDERED IN PART.

Appendix A

Pickering, Circuit Judge, dissenting:

I respectfully dissent.

As an initial matter, I disagree with the majority's conclusion that "unable to perform all of the material and substantial duties of his occupation" can only mean unable to perform "each and every one" of the material and substantial duties of an occupation, so that if an employee can perform even one material and substantial duty of his or her occupation, the employee is not disabled. Although this is a reasonable interpretation of the policy language, the policy language is ambiguous and susceptible to more than one reasonable interpretation. I would interpret the policy provision differently. If there are ten material and substantial duties of an occupation and the employee can perform only six of those ten duties, then the employee is by definition "unable to perform *all* of the material and substantial duties" of the occupation. That too is a reasonable interpretation. The ambiguity should be construed against the insurer. *See Wegner v. Standard Ins. Co.*, 129 F.3d 814, 818 (5th Cir.1997). But to construe the policy differently than the administrator would create an internal inconsistency between the policy provisions for total disability and partial disability. Consequently, though I disagree with the majority's interpretation of the policy, this issue is not outcome determinative.

However, I do respectfully dissent from the majority's conclusion that when a plan administrator initially determines that a covered employee is eligible for benefits and later determines that the employee is not eligible for those benefits,

the plan administrator may terminate benefits without demonstrating that its initial decision was erroneous, or without substantial evidence of a change in the claimant's medical condition.

Because this case involves an insurer who is also the plan administrator, producing a direct conflict of interest on the part of the administrator, we apply a sliding-scale standard of deference to the administrator's decision. *See Vega v. Nat'l Life Insur. Servs.*, 188 F.3d 287, 294-99 (5th Cir.1999). Under such circumstances, this court still applies the abuse of discretion standard, "but gives less deference to the administrator in proportion to the administrator's apparent conflict." *Id.* at 296. Where there is a conflicted administrator, "the administrator has a financial incentive to deny the claim and often can find a reason to do so." *Id.* The court must "focus on whether the record adequately supports the administrator's decision." *Id.* at 298. "[W]e are less likely to make forgiving inferences when confronted with a record that arguably does not support the administrator's decision." *Id.* at 299.

At the summary judgment stage, it is the movant who has the burden of showing that there is no genuine issue of material fact. The parties agree that this claim involves a policy of insurance issued by Liberty. Liberty is the administrator. All reasonable inferences are to be drawn in favor of Ellis. If Liberty pays a claim it is not unreasonable to infer that every penny of the claim comes directly out of Liberty's coffers. Any argument that the administrator did not have a direct and total, or almost total conflict of interest in this situation is to ignore reality. The fox guarding the

chicken house is not entitled to great deference.[1] Thus, in analyzing the administrator's decision to terminate benefits, I would give little deference to the administrator's exercise of discretion.

It is undisputed that the administrator initially determined that Ellis was entitled to disability benefits based on the medical evidence, *and later reaffirmed that fact in the letter of termination.* I would hold as a matter of law, that once the administrator determined Ellis was entitled to disability benefits, a subsequent termination of those benefits would be an "arbitrary and capricious" decision by the administrator, and hence an abuse of discretion, unless there is substantial evidence to support *either* (1) that the initial decision to grant benefits was incorrect; or (2) that there has been a change in condition that would justify the termination of benefits. Once the administrator has exercised its discretion and determined that a claimant is entitled to benefits, a later decision to

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1. The majority in a footnote contends that *MacLachlan v. ExxonMobil Corp.*, 350 F.3d 472, 479 n. 8 (5th Cir.2003), demonstrates that there should be no ipso facto presumption of a conflict. No such presumption is required. The parties admit to the conflict. As this court stated in *MacLachlan:*

> this court's decisions, following *Vega,* that have found an apparent conflict of interest are ones in which a claim was denied by the insurance company that did not employ the claimant, but instead was contractually obligated to make payments under the employer's plan. . . . This is a significant distinction. . . .

Id. at 479 n. 8. This is precisely the factual situation in this case.

terminate those vested disability benefits without justification is by definition arbitrary and capricious and an abuse of discretion. *See Meditrust Financial Servs. v. Sterling Chemicals,* 168 F.3d 211, 215 (5th Cir.1999) (holding that administrator's decision is arbitrary if made without rational connection between known facts and the decision or between found facts and the evidence).

In the termination letter of December 22, 2000, the administrator acknowledged that "it is apparent" that Ellis "met the criteria for [her] policy's definition of disability initially." Thus, in the opinion of the administrator the initial decision to grant disability benefits was correct. The administrator made no effort to show that the initial decision was wrong, but to the contrary, reaffirmed the initial determination. The question then becomes whether there was a change in condition that would justify the later termination of benefits. The majority opinion fails to answer this question.

In the termination letter, the administrator listed (with little explanation of its relevance) the medical evidence used in support of the decision to terminate benefits. The district court analyzed this evidence and found that it did not support the administrator's conclusion to terminate benefits. I agree. I would affirm the district court for basically the same reasons given in the district court's opinion. The record does not adequately support the administrator's decision to terminate benefits because the administrator admitted that the plaintiff was not initially disabled and because there was no substantial evidence of a subsequent change in condition. Thus, the administrator abused its discretion.

Appendix A

The majority contends that the dissent argues that a plan administrator cannot reverse an initial erroneous decision to pay benefits. Contrary to the majority's characterization, I certainly would agree that an insurer can correct an erroneous initial decision to pay benefits, but only if there is substantial evidence to support that decision. But in this case the administrator, Liberty, acknowledged, even in its letter of termination, that the initial determination to award benefits was appropriate.

For the above reasons, I respectfully dissent.

APPENDIX B — MEMORANDUM OPINION AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF TEXAS, HOUSTON DIVISION ENTERED JUNE 3, 2003

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

CIVIL ACTION NO. H-01-3963

LINDA ELLIS,

Plaintiff,

vs.

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON

Defendant.

MEMORANDUM OPINION AND ORDER

I. INTRODUCTION – PROCEDURAL HISTORY

Before the Court for consideration are the reciprocal motions for summary judgment of the plaintiff and the defendant. The plaintiff, Linda Ellis, seeks to recover against the defendant, Liberty Life Assurance Company of Boston on claims of disability that find bases in the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001-1461 *et. seq.*

Appendix B

The plaintiff commenced this suit in state court where she asserted state statutory and common law claims based on violation of the state insurance code, breach of contract, and breach of the duty of good faith and fair dealings. Because the Court finds that the plaintiff's claims arise under a long-term disability benefits policy. The plaintiff's claims are preempted by ERISA and the state law claims asserted are dismissed. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 59 (1987). Pursuant to ERISA's preemption, the defendant caused the plaintiff's suit to be removed to this Court pursuant to 28 U.S.C. § 1441(b). At this time, the Court has reviewed the motions for summary judgment and determines that the plaintiff s summary judgment should be granted and the defendant's motion should be denied.

II. FACTUAL BACKGROUND AND CONTENTIONS

A.

The plaintiff is insured under a disability insurance policy issued and administered by the defendant on behalf of the plaintiffs employer, Chase Manhattan Bank [now J.P. Morgan/Chase]. The plaintiff was first employed with the bank in 1997, where she served as a mortgage loan officer. In 1999, the plaintiff became eligible to receive disability benefits when it was determined that she could no longer perform her duties. After the defendant reviewed the plaintiff's application and claim, benefits were commenced on January 24, 2000. However, on December 22, 2000, the plaintiff received a letter terminating disability benefits.

Appendix B

The plaintiff asserts that the benefits were wrongfully terminated and were terminated without a reasonable stated basis. The plaintiff asserts that her medical condition did not improve during the benefits period and that no evaluation, medical or otherwise, was performed that supports discontinuance of the benefits.

The defendant's response to the plaintiff's motion for summary judgment is included in its motion for summary judgment and supplement. There, the defendant contends that the defendant gave the policy its legally correct interpretation, no substantial conflict of interest exists simply because the defendant serves as both the insurer and administrator of the Plan, and that substantial evidence supports the defendant's decision. Therefore, the defendant asserts, it did not abuse its discretion.

B.

In its letter terminating benefits dated December 22, 2000, the defendant recited the policy definition and its stated reason(s) for terminating the plaintiff's benefit. The relevant portion of the policy that was also recited in the defendant's letter provides:

> If the Covered Person is eligible for the 24 month Own Occupation Benefit, "Disability" or "Disabled" means during the Elimination Period and the next 24 months of Disability the Covered Person is unable to perform *all of the material and substantial duties of his occupation on an Active Employment basis* because of an Injury or Sickness; and [emphasis added].

> After 24 months of benefits have been paid, the Covered Person is unable to perform, with reasonable continuity, all of the material and substantial duties of his own or any other occupation for which he is or becomes reasonably fitted by training, education, experience, age, and physical and mental capacity.

The letter went on to state its basis for the termination of benefits as follows:

> While it is apparent you were ill and met the criteria for your policy's definition of disability initially, based on the medical information received, you no longer meet your Long Term Disability Policy's definition of disability. Therefore, we must close your claim for benefits, effective December 31, 2000.

III. UNDISPUTED FACTS

It is apparent from the plaintiff's and the defendant's papers that there is no dispute as to certain facts. First, the plaintiff never reached a point where the second part of the disability definition came into play. The plaintiff's benefits were discontinued during the first twelve (12) months. Additionally, the undisputed facts show that: (a) the plaintiff was determined eligible for the disability benefits; (b) the entirety of what is known about the plaintiff's medical condition is based upon the reports provided by the plaintiff's physicians; and (c) the definition or interpretation of the term "disability" is not disputed, What appears to be in dispute is

the defendant's interpretation of the medical evidence and its understanding of how to apply the definition of disability under the Plan. The Court will address each of these areas in turn.

A.

The plaintiff's eligibility for disability benefits is admitted by the defendant in its letter of termination. In its December 22 letter, the defendant stated that "it is apparent" that the plaintiff "met the criteria" for disability benefits under the policy. Thus, this issue requires no further comment and the Court moves to the second aspect of this discussion, the medical evidence.

B.

The determination of medical disability was based initially on Doctor Diana Hayes' diagnosis that the defendant was disabled. Dr. Hayes determined that the plaintiff suffered from fibromyalgia and that she was diabetic and insulin dependent. The plaintiff's condition was such that Dr. Hayes determined that the plaintiff suffered a Class 4 physical impairment and a Class 4 mental impairment. These impairments resulted in a finding that the plaintiff was functionally impaired and incapable of performing a full eight (8) hours per day work schedule. Moreover, due to stress and the plaintiff's need to perform substantial driving as a part of her job function, Dr. Hayes cautioned that the plaintiff was unable to perform all of the material and substantial duties of her occupation. That preliminary determination did not change in February.

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In February, Dr. Hayes reiterated her initial diagnosis. She noted also that the plaintiff was suffering from fatigue, weakness and trunk and limb pain. At that time, the plaintiff also complained that simple life functions such as putting on her shoes and socks caused pain. As a result, an EMG was performed in March, which results were consistent with a myopathic process. The plaintiff was diagnosed as suffering possibly from an inflammatory myopathy.

Later in April, Dr. Mavis Fujii, a neurologist examined the plaintiff. He reported impairment of muscles due to pain and, therefore, proposed a muscle biopsy for evaluation. He concluded that the plaintiff was suffering polymyositis, which was causing muscle impairment. Dr. Fujii determined that the plaintiff could not stand, walk, climb stairs, ladders or perform a job that required driving and that she should not lift more than 10 pounds over a substantial period of time. He too, concluded that the plaintiff could not work an eight (8) hour work day.

This conclusion was shared by Dr. Evans Matwijiw, an endocrinologist. Dr. Matwijiw advised the plaintiff that she should not stand more than two (2) hours per day. That she could not perform on the job driving, pushing, pulling, reaching, handling/grasping, and labor that requires five finger dexterity. He determined that the plaintiff was totally disabled.

Dr. Jovan Popovich, a rheumatologist found an elevated CPK, confirmed that the plaintiff's EKG was consistent with the myopathic process, and that she was suffering from fibromyalgia. When the plaintiff's CPK decreased,

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Dr. Popovich sought to determine whether the plaintiff's functionability was increased. He found the contrary-it had worsened. This condition persisted. According to the plaintiff and Dr. Popovich's examination, the plaintiff's condition was consistent with the plaintiff's complaints. As late as August 2000, Dr. Popovich continued to see an elevated CPK, continued to document muscle pain and decreased CPK with worsening of the plaintiff's functional ability. An M1ZI to look for myositis was ordered. And, concerns about supraclavicular soft tissue swelling were the subject of a referral to a surgeon. In September, the MRI revealed enlarged lymph nodes and problems with one of the blood vessels. However, the pain in the muscles and soft tissue continued and inflammatory myopathy was not be ruled out.

On January 31, 2001, Dr. Popovich issued a letter reconfirming her earlier diagnosis of fibromyalgia. She described the plaintiff's condition as chronic, with widespread musculoskeletal pain and fatigue disorder. Dr. Popovich further explained that routine laboratory testing looks normal even though the plaintiffs condition persists.

Thus, the Court concludes that the plaintiff's medical history did not change significantly, if at all during the twelve (12) months that the plaintiff received disability benefits. The Court moves to the final area of dispute between the parties-the issue of whether the plaintiff's benefits were wrongfully terminated.

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C.

The final area of dispute between the parties concerns the application of the definition of the term "disability" by the defendant. Again, there is no dispute between the parties concerning the meaning of "disabled." However, the defendant's litigation manager in her deposition responded as follows:

> Q.: Under that definition [speaking of disability], if Ms. Ellis could not perform one of the material duties of her occupation, she would be disabled?
>
> A.: Yes.

Based on testimony, the defendant's view of the appropriate interpretation of the term "disability" is the same as that of the plaintiff. Therefore, this area does not raise a disputed fact or law issue for the fact finder. Thus, the Court holds that if the plaintiff could not perform any one of the material duties of her occupation, she was entitled to continue on disability benefit.

III. STANDARD OF REVIEW

A. *Summary Judgment Standard*

Summary judgment is proper "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R.

Civ. P. 56(c) (2003). The moving party bears the initial burden of "informing the Court of the basis of its motion" and identifying those portions of the record "which it believes demonstrate the absence of a genuine issue of material fact." *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). In adjudicating a motion for summary judgment, the Court must view all facts in the light most favorable to the nonmoving party. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986) (citing United States *v. Diebold, Inc.*, 369 U.S. 654, 655 (1962)).

Once the moving party meets its burden, the nonmoving party must "go beyond the pleadings" and set forth "specific facts" in the record "showing that there is a genuine issue for trial." *Celetex Corp.*, 477 U.S. at 324. An issue is "genuine" if the evidence is sufficient for a reasonable jury to return a verdict for the nonmoving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-49 (1986). Failure on the part of the nonmoving party to offer proof concerning an essential element of its case necessarily renders all other facts immaterial and mandates a finding that no genuine issue of fact exists. *Saunders v. Michelin Tire Corp.*, 942 F.2d 299, 301 (5th Cir. 1991).

The primary inquiry here is whether the material facts present a sufficient disagreement as to require a trial, or whether the facts are sufficiently one-sided that one party should prevail as a matter of law. *Anderson,* 477 U.S. at 251-52. The substantive law of the case identifies which facts are material. *Id.* Only disputed facts potentially affecting the outcome of the suit under the substantive law preclude the entry of a summary judgment. *Id.*

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In an ERISA case where the insurer also serves as the administrator of an ERISA Plan, the insurer has a financial interest in the outcome of the claim determination. Therefore, a court should give less deference to the insurer's decision in view of this fact. *See Lain v. Unum Life Insurance Company ofAmerica,* 279 F.3d 337, 346 (5th Cir. 2002); *Vega v. National Life Insurance Services, Inc.*, 188 F.3d 287, 302 (5th Cir. 1999). The Court now turns to its analysis.

V. ANALYSIS

At the outset, the Court states its opinion that the defendants arbitrarily discontinued the plaintiff's disability benefits. A review of the medical records show that the plaintiffs medical condition did not change, appreciably between January 2000 to December 2000. Thus, it is apparent that the defendant places greater weight on its video investigation than on the scientific evidence or its own medical expert. The video revealed that the plaintiff would leave home from time-to-time to visit the doctor or shop for groceries. On one occasion the plaintiff was seen carrying what is described as several "large" grocery bags from her car into her home. However, there is no evidence as to what was contained in the bags or whether the weight of the contents exceeded 10 pounds. The medical evidence as well as the plaintiff's activities questionnaire confirm that the plaintiff can lift 10 pounds and more. In addition, the plaintiff admits that she can shop for groceries or do chores like watering her lawn, even though she tries to avoid them due to pain. However, the medical evidence establishes that these activities cannot be sustained over a period of time and with any degree of consistency. Thus, the video is no evidence

and is inadmissible as evidence as to whether the plaintiff can perform all of the material duties of her occupation.

The defendant also sought and secured an independent medical examination, conducted by Dr. Steven M. Croft on November 8, 2000. Dr. Croft confirmed the reports of doctors Lucci, Hayes, Fujii and Popovich. His impression was that the plaintiff suffered a condition, possibly fibromyalgia, although he too was unprepared to make a definite diagnosis. He was "doubtful" that the plaintiff was suffering polymyositis, but confirmed that he did not have sufficient data to rule it out. In fact, Dr. Croft conceded that the plaintiff may have a "very mild case" of polymyositis because that would explain the plaintiff's symptoms. He discounted the fact that the plaintiff complained of constant pain; not because any medical or scientific examination revealed this fact, but because he viewed the video. He concluded that based on his objective finding there is insufficient "evidence" to support the view that the plaintiff is unable to perform her duties in a sedentary job. However, this finding begs the issue because only a part of the plaintiff's duties could be done in a sedentary posture. He failed to speak to the forty (40) percent[1] of the plaintiff's occupation that is not sedentary in nature. Moreover, he seemed to be confused as to what his duties entailed. It was not Dr. Croft's duty to determine whether the plaintiff could work at all. It was to determine whether she could do all of the critical functions of her

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1. The defendant admits that only 60% of the plaintiff's occupation function is sedentary. The remainder requires, lifting, standing, reaching walking and driving. In fact, 20% of the plaintiff's occupation requires driving under stressful circumstances.

occupation. For the plaintiff, this would include functions other than sitting, and would require a full day's work.

The record shows that no tests were done by Dr. Croft that resulted in "objective" findings contrary to those found by the other physicians. Beyond the physical examination and review of the plaintiff's treating physicians, no separate tests were reported. Interestingly, Dr. Croft states that when he palpated the plaintiff's shoulder and thigh muscles, the plaintiff almost became tearful and complained of pain. Finally, Dr. Croft admitted that a repeat EMG and an evaluation by an independent rheumatologist would be appropriate.

The Court is of the view that Dr. Croft's use of terms "doubtful" and "possible" and his confusion as to the disability standard at issue renders Dr. Croft's medical determination immaterial. Thus, his examination was based on insufficient medical evidence to reach a conclusion different than that reached by the plaintiffs treating physicians. In fact, Dr. Croft does not conclude that the plaintiff can perform all the material duties of her occupation. Instead, he simply concludes that she can work in a sedentary occupation. This conclusion misses the mark.

Thus, the Court concludes and holds that the independent report of Dr. Croft fails to create a disputed fact issue for the fact finder. Equally important, the report fails to refute the medical findings upon which the defendant first made its determination that the plaintiff was eligible for disability benefits.

The Court, therefore, FINDS and HOLDS that there is no credible, substantial or positive evidence that demonstrates that the plaintiff, once eligible, became ineligible for disability benefits. Further, there is no evidence to support the conclusion that the plaintiff can perform all of the material duties of her occupation as a mortgage loan officer. Finally, the independent medical examination does not address the issues of disability, as defined by the policy. Therefore, the defendant abused its discretion in applying a disability standard different than the standard established in the policy and summary judgment is appropriate for the plaintiff.

It is Ordered that the defendant provide a full accounting of benefits owed the plaintiff from January 1, 2001, to the date of this Memorandum and Order to the Court within ten (10) days of entry of this Order. Also, the defendant's counsel shall file, if appropriate, a cross-affidavit concerning the reasonableness of the plaintiffs counsel's attorney's fee within ten (10) days of the entry of this Order. [*See* attachment 57 to the plaintiffs supplement to its motion for summary judgment, Inst. No. 22].

Signed this 2nd day of June, 2003.

s/ Kenneth M. Hoyt

KENNETH M. HOYT
United States District Court Judge

APPENDIX C — SUPPLEMENT TO MEMORANDUM OPINION AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF TEXAS, HOUSTON DIVISION DATED JULY 31, 2003

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

CIVIL ACTION NO. H-01-3963

LINDA ELLIS,

Plaintiff,

vs.

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON

Defendant.

SUPPLEMENT TO MEMORANDUM OPINION AND ORDER

The Court finds it appropriate to supplement its Memorandum Opinion and Order entered on June 3, 2003. The necessity to supplement is based on the Court's implied finding that the defendant intentionally violated the law in denying disability benefits to the plaintiff. [*See* Memorandum Opinion and Order, p. 6(c)], and did so in bad faith.

The record reveals that the defendant's litigation manager was aware and agreed that the plaintiff qualified for disability benefits. Yet, the defendant set out to prove that the plaintiff

was capable of engaging in certain activities. This diversion by the defendant was intentional and calculated to harm the plaintiff. Even after the plaintiff qualified for disability according to Social Security standards, the defendant would not yield. Moreover, the defendant has had many opportunities to reexamine the plaintiff and its position and has failed to do so. Therefore, the Court is of the opinion that the plaintiff is entitled to an award of attorney's fees, prejudgment interest. *See* 29 U.S.C. § 1132(g)(1); *see also Hansen v. Continental Ins. Co.*, 940 F.2d 971, 984 (5th Cir. 1991).

The Court is also of the opinion that the defendant's bad faith and ability to pay an attorney's fee are not an issue. An award of attorney's fees would serve the ends of justice and deter other similar conduct. *See Salley v. E. I. Dupont de Nemours & Co.*, 966 F.2d 1011, 1017 (5th Cir. 1992).

It is, therefore, the opinion of the Court that the additional relief requested by the plaintiff should be granted.

It is so ORDERED.

Signed this 31st day of July, 2003.

s/ Kenneth M. Hoyt
KENNETH M. HOYT
United States District Court Judge

APPENDIX D — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT DENYING PETITION FOR REHEARING FILED JANUARY 14, 2005

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 03-20623

LINDA ELLIS

Plaintiff - Appellee-Cross-Appellant

v.

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON

Defendant - Appellant-Cross-Appellee

Appeal from the United States District Court for the Southern District of Texas, Houston

ON PETITION FOR REHEARINGAND REHEARING EN BANC

(Opinion 11/19/04, 5 Cir., ____, ____ F.3d ____)

Before JOLLY, WIENER and BARKSDALE, Circuit Judges.*

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* Judge Pickering was a member of the original panel but retired from the Court on 12/8/04 and, therefore did not participate in this decision.

Appendix D

PER CURIAM:

The Petition for Rehearing is DENIED and no member of this panel nor judge in regular active service on the court having requested that the court be polled on Rehearing En Banc, (FED. R. APP. P. and 5TH CIR. R. 35) the Petition for Rehearing En Banc is also DENIED.

ENTERED FOR THE COURT:

/s/ Jacques L Wiener, Jr
United States Circuit Judge